CONDITIONS OF SERVICE

Thank you for choosing Physicians Vein Clinics. This document represents our established *Conditions of Service* that will be used to resolve any issues or disputes pertaining to vein care services rendered by Physicians Vein Clinics physicians and staff.

CONSENT TO TREATMENT

The patient identified below consents to therapeutic vein care evaluations and treatments which may be performed or assisted by Physicians Vein Clinics vein specialists while under the care of Dr. Hansen. These evaluations and treatments may include, but are not limited to, initial evaluation or consultation, history & physical examination, lower extremity venous ultrasound study, infiltration of tumescent local anesthesia, endovenous laser ablation (EVLA), endovenous chemical ablation (EVCA) or sclerotherapy, ultrasound-guided sclerotherapy, vein light sclerotherapy, and/or conservative vein therapy.

PRIVATE PAY

For patients having no insurance, or choosing not to bill their insurance, it is expected that all vein care services will be paid in full prior to services, or at the time of service if arrangements for payment have been made acceptable to Physician's Vein Clinics. In all cases, accounts must be resolved in full within ninety (90) days. Accounts not resolved within ninety (90) days will be referred to an outside collection agency.

ASSIGNMENT OF INSURANCE OR HEALTH PLAN BENEFITS

I, the undersigned, represent that I have insurance coverage with, and do hereby authorize my insurance company to pay and assign directly to a Physicians Vein Clinics surgical and/or medical benefits, if any, otherwise payable to me for services at a rate not to exceed Physician's Vein Clinics regular charges for those services. It is agreed that payment to Physicians Vein Clinics pursuant to this authorization by an insurance company or health plan shall discharge said insurance company or health plan of any and all obligations under the policy to the extent of such payment. I understand that I am financially responsible for all charges not covered by this assignment. I hereby authorize said assignee to release all information necessary to secure the payment of said benefits.

Our clinic does not accept foreign insurance as a source of payment. These types of accounts will be categorized by Physicians Vein Clinics as Private Pay, and must adhere to the guidelines set forth above in the Private Pay section.

MEDICARE PATIENT'S ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize release of any information needed to act on this request. I request that payment of authorized benefits be made on my behalf. I assign payment for the unpaid charges of the physician charges for his services. I understand I am responsible for any remaining balances.

Physicians Vein Clinics does accept Medicare. If you have a supplemental insurance, depending on your plan, they may cover the remaining 20% that Medicare does not cover. You will be responsible for any balances that the supplemental insurance does not cover. If you do not have supplemental insurance, you are responsible for the remaining 20% on all services provided.

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PERSONAL VALUABLES

It is understood and agreed that Physicians Vein Clinics shall not be liable for the loss or damage to any money, jewelry, documents, fur garments, dentures, eye glasses, hearing aids, prosthetics, or other articles of unusual value and small size. Also, Physicians Vein Clinics shall not be liable for loss or damage to any other personal property.

CONSENT TO PHOTOGRAPH / VIDEOTAPING

Physicians Vein Clinics s permitted to take pictures of the medical or surgical progress involving vein care. The patient consents to photography and/or videotaping during medical or surgical procedures and the use of same for scientific, educational or medical research purposes. The patient further consents to routine photo-documentation related to patient care.

FINANCIAL OBLIGATIONS

I understand that I am responsible to Physicians Vein Clinics for all charges incurred by me and not paid by third party benefits. In the event that said bill, or any part thereof, is deemed delinquent by the practice, I understand that I will be responsible for collection of expenses as well as reasonable attorney's fees and court costs if a suit is instituted. All delinquent accounts shall bear interest at the maximum rate allowed by law.

CANCELLING APPOINTMENTS

I understand that I am responsible for notifying Physicians Vein Clinics at least 48-hours before my scheduled appointment if I am unable to keep said appointment. Failure to do so may result in my account with Physicians Vein Clinics being assessed a $100 cancellation fee for breach of notification of each scheduled appointment.

RELEASE OF INFORMATION

Physicians Vein Clinics will obtain the patient's consent and authorization to release protected health information concerning the patient, in accordance with HIPAA regulations, except in those circumstances when Physician's Vein Clinics is permitted or required by law to release information. For further info, please see the 'Notice of Privacy Practices' at Physicians Vein Clinics.

SEVERABILITY

If any terms or conditions of this agreement are held by a court of law to be invalid or unenforceable, then this agreement, including all of the remaining terms and conditions, will remain in full force and effect as if such invalid or unenforceable term or condition had never been included. My signature below acknowledges that I have received a copy of this document and accept its terms.

Patient or Responsible Party Signature: _____

Printed Name: _____ Date Signed: _____ / _____ / _____